Health Insurance Application Instructions -- PAGE 1
FOR EMPLOYERS *IN* THE STATE PAYROLL SYSTEM - *UPPS*

Reason for Application

- **New Employee:** Check this box if you are a new employee of an agency that participates in the Public Employee Health Insurance Program.
- **New Group:** Check this box if your employer is joining the Public Employee Health Insurance Program for the first time.
- **COBRA:** Check this box if you are applying for COBRA coverage (Your Insurance Coordinator will mail this application directly to the Health Insurance Carrier).
- **FSA Only:** Check this box if you are enrolling in a Flexible Spending Account for the first time due to a Qualifying Event. Complete Sections I, VI and VII.
- **Other:** Check this box if none of the listed options apply. The Insurance Coordinator must provide an explanation if "Other" is selected.
- **Open Enrollment:** Check this box if you are filling out this application for Open Enrollment. If you currently waive your health insurance and wish to continue as a waiver for the next plan year and only want to file your FSA information during an open enrollment period, use Open Enrollment. Do not use FSA Only.
- **Move Out of Service Area:** Check this box if you are requesting a change to your current health coverage because you have moved out of your service area. You must provide the date of the qualifying event in the space provided below. All other qualifying events do not require an application and do require an ADD or DROP Form Only. You can request the ADD or DROP Form from your Insurance Coordinator.
- **Previously Waived:** Check this box if you previously waived your health insurance coverage and have now experienced a qualifying event that allows you to select health insurance coverage. You must provide the date and description of the qualifying event in the spaces provided below. All other qualifying events do not require an application and do require an ADD or DROP Form Only. You can request the ADD or DROP Form from your Insurance Coordinator.

TO THE INSURANCE COORDINATOR: Complete the information in the shaded box in the top right hand corner of the application.

- Enter the effective date of coverage.
- Enter the employee's company number.
- If the employee selects coverage in his/her Home OR Work county, you are required to enter both the Home AND Work county codes. If the employee selects coverage in his/her Contiguous county, you are required to enter the Home, Work AND Contiguous county codes. Notice that the employee is only required to name the county of residence in Section I and the county of choice in Section II, #1; however, **you are required** to provide the Home and Work County codes, and the Contiguous county code, where applicable.
- Enter the dual employee indicator, if applicable. This number may range from 0-9. For more details, you may contact your agency's Payroll Officer. Leave this code blank if the employee is not a dual employee.

SECTION I: DEMOGRAPHIC INFORMATION – Please PRINT clearly.

- Enter the policyholder's Social Security Number, Date of Birth, Name (First, MI, Last), Address (including County of Residence), Gender, Marital Status, Hire Date, Employer's Name and the policyholder's Daytime Phone Number.

SECTION II: PLAN SELECTION

1. **County of Coverage: Check ONLY one.**
   - **HOME:** If you are electing coverage in the county where you live.
   - **WORK:** If you are electing coverage in the county where you work.
   - **CONTIGUOUS:** This is an additional choice if you live and work in certain counties in the Commonwealth designated as "Contiguous Counties". If you live and work in any of the specified counties, you could choose coverage in the county designated as "Hospital County" that is contiguous to your county of residence. Refer to the Health Insurance Handbook for more information about this option.
   - Enter the name of your county of coverage in the space provided.

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2. **Plan Code:** Indicate which health insurance plan you are selecting by entering the three (3) digit code that identifies the health insurance plan. **You will find the code numbers in the Health Insurance Handbook next to the plan name on the Rate Chart.**

   IMPORTANT: **If you are WAIVING coverage, enter 999 as the plan code and go to Section VI on Page 2.**

   Remember that WAIVING your health insurance DOES NOT automatically direct your money into a Flexible Spending Account. In order to direct any employer or employee contribution into a Flexible Spending Account, you must complete Section VI of this application.

3. **Option:** Mark the box that indicates the option you are selecting (A or B). For a description of the two options, see the Health Insurance Handbook. No Option is needed if you are selecting an EPO plan. **Select only one**.

4. **Level of Coverage:** Mark the box that indicates the level of coverage you are selecting. For a description of each level of coverage, see the Health Insurance Handbook. **Select only one**.

5. **Payment Option:** You may elect to have the monthly insurance premium deducted one time per month (Monthly) or from each paycheck (Twice Monthly). Mark the appropriate box to indicate which payment option you are selecting. **If you fail to select a payment option, you will be set up for Twice Monthly. Select only one**.

6. **Cross Reference:** If you wish to cross-reference, mark this box and complete Section IV. **ONLY ONE** application is required. The person listed in *Section I: Demographic Information* will be the policyholder.

7. **PCP Selection**: If it is required by the plan you select, enter the Primary Care Physician Number listed in the plan provider directory and indicate if you are currently a patient of that physician.

SECTION III: PRIOR HEALTH COVERAGE

- If you or any eligible dependents were covered by any health insurance plan during the last twelve months, complete this section. It is essential that you answer the questions in this section so you may be given proper credit toward meeting the waiting period for any pre-existing condition.

SECTION IV: SPOUSE AND/OR DEPENDENT INFORMATION

Complete this section only if you are covering your eligible **spouse, dependent child(ren)** or **cross referencing** on your health insurance plan. Enter the required information for each dependent that you wish to cover. If you need additional space, use Page 1 of another health insurance application. Do not complete this Section if you are selecting Single coverage.

Rel. Code: Enter the appropriate relationship code as follows:
SP → Spouse (your eligible spouse).
CH → Child (your eligible child, step child, adopted child, foster child or your grandchild that is considered your dependent for Federal Tax purposes and who is not disabled).
DD → Disabled, Dependent Child (your eligible disabled child). If your disabled, dependent child is 24 years old or older, your health insurance carrier will request evidence of his/her disability.
CO → Court Ordered Dependent Child (an eligible, dependent child that you are court ordered to carry on your health insurance or an eligible, dependent child of whom you have full guardianship).

TO THE INSURANCE COORDINATOR

The shaded box at the bottom of Section IV must be completed by the spouse's Insurance Coordinator ONLY if the policyholder is applying for a cross-reference plan. Applications will not be processed without the spouse's company number. The Spouse's Dual Employee Indicator is only applicable to some employers. If the spouse is not a dual employee, leave this code blank. If the spouse is a dual employee, enter the dual employee code.

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Enter the social security number of the policyholder in the spaces provided on the top right hand corner of Page 2 (same as SSN in *Section I: Demographic Information*).

SECTION V: CUSTODIAL PARENT INFORMATION

- Complete this section if you have a **Court Order** or an **Administrative Order** to cover an eligible dependent(s) on your health insurance who does not live with you.
- Print your dependent's social security number in the boxes provided.
- Print the custodial parent's name and address in the lines provided. If the custodial parent is the same for each dependent, check the Yes box for "All Dependents?" and complete the custodial parent's name and address only once. If the custodial parent is different for each dependent, complete the appropriate information using an additional Page 2.

Remember that Court Ordered dependents MUST be listed in Section IV, Page 1.

SECTION VI

Enrollment in a Flexible Spending Account is OPTIONAL. By completing this Section, you will be enrolling in a Flexible Spending Account.

Remember that WAIVING your health insurance DOES NOT automatically direct your money into a Flexible Spending Account.

Health Care Spending Account

Employer Contribution per Paycheck: Enter the amount of employer contribution you are eligible to receive by subtracting the cost of your plan from the employer contribution in your county of choice. If there is no amount remaining, enter 0. Refer to the Health Insurance Handbook for employer contribution information by county. If you are waiving your health insurance coverage (Code 999 in Section II, #2), enter $117.00 on this line.
Participant Contribution per Paycheck: Enter the amount that you want deducted from each paycheck.
Sub-Total per Paycheck: Add the Employer Contribution per Paycheck and the Participant Contribution per Paycheck. This amount must not exceed $120.00 per paycheck.
Number of Expected Paychecks: Enter the number of expected paychecks.
Total Contribution for Plan Year: Enter the total contribution amount for the entire coverage period. (Sub-Total per Paycheck times Number of Expected Paychecks)

EZ Reimburse Card: To **decline** enrollment in the EZ Reimburse Debit Card plan, you **must mark** the EZ Reimburse Card check box. If you do not decline, $6.00 will be deducted from your account. The EZ Reimburse Debit Card plan is only applicable to the Health Care Spending Account.

Dependent Care Account

Mark the tax filing status that applies to you.
Participant Contribution per Paycheck: Enter the amount that you want deducted from each paycheck.
Number of expected paychecks: Enter the amount of expected paychecks.
Total Contribution for Plan Year: Enter the total contribution amount for the entire coverage period. (Participant Contribution per Paycheck times Number of Expected Paychecks)

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SECTION VII: AUTHORIZATION AND CERTIFICATION

Read the statements in this section carefully. After you have read and understood the statements, sign your name on the "Employee Signature" line and write today's date in the line provided.

If you are applying for **a cross-reference plan**, your **spouse MUST also sign** the application on the "Spouse Signature" line. He/she **must also write today's date** in the line provided.

Your cross-referenced spouse must have his/her insurance coordinator sign this form before you return it to your insurance coordinator.

Your **cross-reference application** will not be processed without the **four required signatures and dates**: policyholder, spouse, policyholder's insurance coordinator and spouse's insurance coordinator.

GENERAL REMINDERS:

DO NOT HOLD YOUR APPLICATION UNTIL THE END OF OPEN ENROLLMENT. RETURN YOUR APPLICATION TO YOUR INSURANCE COORDINATOR AS SOON AS POSSIBLE.

IF YOU ARE PLANNING TO CROSS-REFERENCE, IT IS VERY IMPORTANT THAT YOU START THE APPLICATION PROCESS AS EARLY AS POSSIBLE. AGAIN, A CROSS-REFERENCE PLAN REQUIRES ONLY ONE APPLICATION WITH FOUR DIFFERENT SIGNATURES.

NOTE THAT ADDITIONAL COPIES OF THE COMPLETED APPLICATION MAY NEED TO BE MADE IF CROSS REFERENCING TO ENSURE THAT ALL PARTIES KEEP A COPY FOR THEIR RECORDS.